PRINTED: 08/14/2014 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G	' '	ATE SURVEY OMPLETED
		175532	B. WING			C 08/14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		STREET ADDRESS, CITY, STATE, ZIP COD 2114 N 127TH CT EAST WICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 00	00		
F 223 SS=G	complaint investigation Extended Health Resident Health Reside	(1)(i) FREE FROM RY SECLUSION right to be free from verbal, I mental abuse, corporal bluntary seclusion. use verbal, mental, sexual, broporal punishment, or	F 2:	23		
	Findings included:					
	and physical dated 4 diagnosis: encephalo describe brain diseas covering a very broad					
	Review of resident #	3's profile page revealed the				
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	·	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING				C 14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		211	REET ADDRESS, CITY, STATE, ZIP CODE 14 N 127TH CT EAST CHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	readmitted on 4/17/1 Review of resident # (minimum data set) or resident had a short- his/her long-term medicould identify staff nathe/she was in a nursy moderately impaired decision making. The mental status change. The resident had inathinking, and psychological fluctuated. The resident had a transport in the staying asleep, or sleep had little energy 2-6. The resident had a transport in the staying asleep, or sleep had little energy 2-6. The resident had a transport in the staying asleep, and an indwelling calling mild depressonal hygiene, and an indwelling calling memory and cassessment) dated that a diagnosis of the expected to cause diresident was alert and at times. The resider admitted to hospice continued decline. To communication was	ly admitted 11/1/13, and 4 and 5/30/14. 3's significant change MDS dated 6/3/14 revealed the term memory problem but mory was ok. The resident ames and faces and knew ing home. The resident had cognitive skills for daily e resident had an acute e from his/her normal status. Itention, disorganized motor retardation that ent had trouble falling or ept too much and felt tired or days of the previous 14 days. Itention, the resident did not is. The resident required total for more staff for toileting, and bed mobility. The resident theter and was frequently 3's Cognitive Loss/Dementia and disorder characterized by confusion) CAA (care area is/10/14 revealed the resident terminal (progressive disease eath) dementia and the doriented to him/herself only it was very lethargic and services due to expected the resident 's limited and staff often had ing the resident due to	F:	223			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	, 337.7.23
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 223	dated 6/10/14 reveal for increased bowel is extensive assistance resident wore incontil was dependent on stresident had an indw depended on staff for Review of resident # dated 7/18/14 reveal (brief interview for mindicating moderate in inattention and disorpersent and fluctuate had little energy and asleep, or slept too in previous 14. The resident did not delusions, or any believe required extensive attoileting and personal assistance of one staff and walking in the rocontinent of bowel are bladder. Review of resident # CAA dated 8/1/14 rediagnosis of dementification with periods of confurmate his/her needs staff assistance in desimpaired cognition. Testident of the staff assistance in desimpaired cognition.	are defined by Catheter CAA and the resident was at risk incontinence due to requiring to fe two staff for toileting. The ment briefs for dignity and the resident had a fer catheter care. By significant change MDS and the resident had a BIMS and the resident had a BIMS and the resident had a BIMS and the resident felt tired or had trouble falling or staying much for 2-6 days of the ident had a total mood andicating minimal depression. The resident sistence of one staff for all hygiene and limited aff for transfers, bed mobility, om. The resident was always and occasionally incontinent of and was alert and oriented sion. The resident could known. The resident required accision making due to	F 22	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C 08/14/2014	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	, 00.1.20.1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION	
F 223	dated 8/1/14 reveale occasional urinary in urinary frequency an with a recent UTI (ur the resident received required extensive as personal hygiene and dignity. Review of resident # initiated on 2/26/14, preferred to sleep in, assistance of one sta 7/18/14 and again or intervention to say the in and required exterwith morning cares. diagnosis of insomni into the morning, he/and sometimes skipp schedule portion of the 2/26/14, revealed the bowel and bladder as with toileting. Staff re 2/26/14 to include for the toilet for safety, massistance when need an intervention alertificontinent of bladder requested staff assis It also directed staff in needed and alerted so not to have caregived personal cares. On 8	ing Foley Catheter CAA d the resident had continence and his/her d incontinence had increased inary tract infection) which I antibiotics for. The resident esistance with toileting and d wore incontinent briefs for 3's comprehensive care plan revealed the resident and required extensive aff with morning cares. On a 8/4/14, staff revised the resident preferred to sleep asive assistance of one staff The resident had a current a and when he/she slept late she could eat breakfast late bed lunch. In the toileting he care plan, also initiated on a resident was continent of and requested staff assistance evised the intervention on a staff to assist the resident to monitor pericare, and provide eded. On 7/18/14, staff added and staff the resident was ar and continent of bowel and stance for toileting for safety. The opposite gender for all 4/14, staff revised the mot indicate what portion of	F 22	3		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION G	(X	3) DATE SURVEY COMPLETED
		175532	B. WING _			C 08/14/2014
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	ge 4 note for resident #3 dated	F 2	23		
	7/14/14 revealed the	e resident sometimes skipped ne/she liked to sleep in per the				
	Review of a nurses resident #3 still had	note dated 7/14/14 revealed some confusion.				
	a.m. revealed reside place, and time, and The resident was in- continent of bowel. assistance of 1 persidally living). The res	noted dated 7/15/14 at 2:19 ent #3 was alert to person, I could voice his/her needs. continent of bladder and The resident required limited con with ADLs (activities of ident rested in his/her bed at did not indicate the resident				
		note dated 7/15/14 at 6:05 sident 's cognition continued				
	7/16/14 at 2:24 a.m. alert and oriented to could voice his/her r bed alarm which state hour checks while the room. The resident of one person with a wheeled walker, toil rested in his/her bed Review of a nurses a.m. revealed the reto person, place, an	note for resident #3 dated revealed the resident was person, place, and time and needs. The resident had a ff utilized along with every 2 ne resident was in his/her required extensive assistance ambulation with a front eting, and ADLs. The resident d at that time. Inote dated 7/17/14 at 12:50 isident was alert and oriented d time and could voice his/her rested in his/her bed at that				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	08/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLE	TION
F 223	p.m. revealed resid	nge 5 note dated 7/17/14 at 11:51 lent #3 was alert and oriented mes and the resident slept at	F 22	23		
	Review of resident July 2014 revealed	#3 's behavior charting for the resident had 2 episodes of 7-7/31/14, both on 7/23/14				
	social services staff several weeks prio that he/she would p nursing staff of his/ resident did not list about a staff member resident was confured of the conversation charge nurse and a resident's request to	statement from the former f B dated 7/23/14 revealed r, the resident had told him/her prefer to receive showers from ther same gender. The anyone specific or complain the opposite gender. The sed at times during the course the social worker let the administrator know of the o have a staff member of the give him/her a shower.				
	7/23/14 revealed the nurse of the opposed and he/she was under member being in hesitated and explay opposite gender with him/her while he/shwall and would tour nursing staff told the checking to see if he dry, but the resider that was correct. The situations happening nursing staff of the	aily progress note dated the resident stated he/she had a tite gender that worked at night comfortable with that staff is/her room. The resident ained the staff member of the build come in and touch the was in bed and facing the the his/her buttocks. That the resident he/she was this/her incontinence pad was that stated he/she did not think the resident described other that and the non-Caucasian opposite gender (henceforth lleged perpetrator- A.P.) would				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			, ,	TE SURVEY MPLETED			
		175532	B. WING _			C 98/14/2014	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP COI 2114 N 127TH CT EAST WICHITA, KS 67228		00/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 223	him/her. The resider when most of the stand him/her outside rough with him/her in afraid if he/she told atrouble. The therapy resident and the resident and the resident and the resident stated noth previous couple of mursing staff of the station and when the resident stated noth previous couple of mursing staff of the station and when the restroom, the A.P. was resident's family me that past Sunday (7/A.P. had not returner resident stated the Aron the night his/her night. The resident range anything. Review of a notarize therapy staff D date contained the same OT therapy note from Review of a notarize therapy staff up a notarize therapy staff up a notarize therapy staff up a notarize therapy note from Review of a notarize anything and the same of the same of a notarize therapy note from the night and the same of the same of a notarize therapy note from the night and the same of the same of a notarize therapy note from the night and the same of the same of a notarize therapy note from the night and the same of the same of a notarize the same	and said it was good for ant described the last holiday aff were gone, and the A.P. in the courtyard and was an the grass. The resident was anyone, he/she would be in a staff then reassured the ident stated he/she was at night. The resident told the B he/she did not want a groof the opposite gender with the rand the social worker told resident had requested same gender only. The ing had happened the hights before 7/23/14, but working out by the nurses the resident got out of his/her was gone. The resident as scared because the mber had stayed the night (20/14) and that is why the last of his/her room. The A.P. came into his/her room family member stayed the reported he/she feared the against him/her if he/she said and witness statement by driving and the information included in the	F 2	23			

				(X3) DATE SURVEY COMPLETED	
	175532	B. WING		C 08/14/2014	
	REEDS COVE	:	2114 N 127TH CT EAST	1 00/14/2014	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
staff C and then both administrative staff A the conversation and explained to him/hele behavior. Staff D was administrative staff A following day on 7/2 Review of a notarized 7/31/14 from the rap went with the staff A reported to staff progress note. Per that the schedule and talked about worked could not be the A.F. administrative staff A had stayed out of the thought because the scared him/her off. It stated the resident was taff D both told staff decreased memory person, place, and the staff C wrote in the resident had reported functioning for thinking know if (gender) is a fitter someone else. Review of the resided dated 7/31/14 reveal having a rough time almost died because resident 's statements omething bothering staff.	h of them went to A and staff D verbally reported d concerns that the resident reabout inappropriate ote he/she gave A a written statement the 4/14. Bed witness statement dated by staff C revealed he/she aff D to administrative staff A to talk about what the resident of D, as written in the OT daily the statement, staff A looked said the person the resident of A that the A.P. worked, but the resident to a statement, staff A looked said the person the resident of A that the A.P. worked, but the resident to state a statement, staff A looked said the person the resident of A that the A.P. worked, but the resident to statement, staff A looked statement the statement, staff A looked statement the statement that but was alert and oriented to sime, and was not confused. Statement the things the lad were higher level of long, as the resident said "I look bothering me, (gender) is here." Bent's notarized statement led the resident had been while at the facility and the he/she got very sick. The lot included there had been go him/her and he/she reported	F 223			
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGULATORY OF Staff C and then both administrative staff A the conversation and explained to him/het behavior. Staff D war administrative staff A following day on 7/2 Review of a notarize 7/31/14 from therapy went with therapy st s office on 7/23/14 th had reported to staff progress note. Per th at the schedule and talked about worked could not be the A.F administrative staff A had stayed out of th thought because the scared him/her off. I stated the resident we staff D both told staff decreased memory person, place, and th Staff C wrote in the resident had reporter functioning for thinki know if (gender) is r after someone else Review of the reside dated 7/31/14 reveal having a rough times aresident 's statement something bothering it to a staff member.	CORRECTION IDENTIFICATION NUMBER:	A BUILDING B. WING	ROVIDER OR SUPPLIER ALTH AND REHAB AT REEDS COVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 7 staff C and then both of them went to administrative staff A and staff D verbally reported the conversation and concerns that the resident explained to him/her about inappropriate behavior. Staff D wrote he/she gave administrative staff A a written statement the following day on 7/24/14. Review of a notarized witness statement dated 7/31/14 from therapy staff C revealed he/she went with therapy staff D to administrative staff A to looked at the schedule and said the person the resident talked about worked all those nights, so he/she could not be the A.P. Staff C said to administrative staff A that the A.P. worked, but had stayed out of the resident 's family member scared him/her off. Per the statement, staff A stated the resident was confused. Staff C burst on formation of the statement thad decreased memory but was alert and oriented to person, place, and time, and was not confused. Staff C wrote in the statement the things the resident had reported were higher level of functioning for thinking, as the resident tadded 7/31/14 revealed the resident had been having a rough time while at the facility and almost died because he/she got very sick. The resident's statement included there had been something bothering him/her and he/she reported it to a staff member. The statement included there had been something bothering him/her and he/she reported it to a staff ember. The statement included there had been something bothering him/her and he/she reported it to a staff ember. The statement included there had been something bothering him/her and he/she reported it to a staff ember. The statement included there had been something bothering him/her and he/she reported it to a staff ember.	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING						
			/ " 50.25	_		، ا	С
		175532	B. WING				14/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2014
					114 N 127TH CT EAST		
AVITA HE	ALTH AND REHAB AT	REEDS COVE			VICHITA, KS 67228		
(V4) ID	SIIMMADV	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 223	Continued From pa	ge 8	F	223			
	· ·	any proof, but there had been					
		im/her. It had not happened					
	_	d gone on for the last couple					
		e spring. The statement					
		r was a non-Caucasian of the					
	opposite gender an	d told the resident he/she was					
	a nurse. The reside	nt ' s family member stayed all					
		go and the A.P. tried to come					
		dent thought it scared the A.P.					
	_	saw the resident 's family					
		atement, for 3 days after that,					
	_	ay. The resident 's statement					
		lways had an excuse that g on something to be sure the					
		The resident reported in the					
		new his/her memory was not					
		he knew what had happened					
		ng to the statement, the A.P.					
		ent 's room late at night					
		nd said he/she was trying to					
	see if the residents	pants were wet and the A.P.					
	would touch his/her	bottom. The resident 's					
	statement indicated	he/she did not make it sound					
	_	was. The resident 's					
	statement included	the same incident reported to					
	•	3/14. The resident did not					
		was trying to do, but the					
		on the arms and it made the					
		ne finally gave up. Per the					
		had come back and tried to					
	_	resident had fought him/her statement said he/she lay					
		ared the A.P. would come					
		the resident it would make					
		nd it was "healthy" for					
	_	nt 's statement indicated					
		nk what else the A.P. would					
		had not fought him/her off.					
		t go to bed until after 1:00					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 08/14/2014	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT I	REEDS COVE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 114 N 127TH CT EAST VICHITA, KS 67228	1 00/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 223	The resident 's stat should be disturbed resident was. The rememory could be baresident knew he/shor he/she would not all night. The reside abuse had gone on there were a lot of timessed "with him/ the statement he/she/she saw the A.P. over it. Review of an OT da 7/28/14 revealed the rather die and go to non-Caucasian staf him/her. Review of an OT da 7/29/14 revealed the 11:30 a.m. and the until 1:00 a.m. beca asleep in fear the A room. Review of a social selection of the staff and following the staff	and awake being afraid about it. In their sleep as much as the esident acknowledged his/her and sometimes, but the line was not imagining anything anythere and worry about it into a statement indicated the for a couple of months and imes the A.P. came in and "inher. The resident reported in the was very scared every time and had lost a lot of sleep willy treatment note dated the resident stated he/she would heaven than put up what the for the opposite gender did to the resident stated he/she was up use he/she was afraid to fall in the resident worker met with the form. The resident knew the som. The resident knew the	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		· /	COMPLETED				
		175532	B. WING _			C 08/14/2014	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT R	EEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u>`</u>	1 00/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 223	care staff E worked a - 10 p.m.) and 3rd (1 different house. Per on yet another house the week of 8/3/14-8 scheduled to work in resident #3 lived in, oshifts (2nd and 3rd) of Review of the 24 hou July 2014 revealed from 7/3/14 day shift- The opposite gender aide 7/7/14 day shift- Staff self-transfers and vo 7/8/14 night shift- Tha.m. and unmade his the bed alarm. Observation on 7/31, get to the resident's the hall into a foyer a around another combed was located behaven was not visible resident's bed was a or the hallway. Interview on 7/31/14 resident's family mer especially had a prolopposite gender. The reported direct care staff member of the cand reset the resider he/she thought that the Resident #3's family Resident #3's family Resident #3's family staff resid	d 7/29/14. On 8/2/14, direct a double shift for 2nd (2 p.m. 0 p.m 6:00 a.m.) shift in a facility report staff E worked a for 3rd shift on 8/1/14. For /9/14, direct care staff E was a different house than on 8/3/14, and for double on 8/8/14 and 8/9/14. Our nurse report sheets for our resident #3: resident did not want any es.	F 2	23			

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			A. BOILDI			, ا	С
		175532	B. WING				14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE	•	2114	EET ADDRESS, CITY, STATE, ZIP CODE N 127TH CT EAST HITA, KS 67228		
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F 223	he/she knew him/hreported the reside information included atted 7/23/14. The night the he/she storme in and may be see him/her. The fing that the tresident confidence in goin At that time, the farm facility had not talk incident all. The farm had talked with the to social services they did not believ happened. The farm were only 2 staff thresident 's house helped cover other reported to the farm staff E not to come other staff that. The he/she had talked several times and always the same ron 7/23/14. The fadid not believe any were related to start always taught ther of their differences. Interview on 8/5/14 resident's family mad not ever ment shift staff of the open staff staff of the open staff of the op	and seemed to be the person her to be. The family member ent told him/her the same ed in the OT daily progress note er family member reported the tayed with the resident, staff Enave been a little shocked to family member reported he/she did not have as much go to sleep as he/she did before. In mily member reported the field to him/her about the mily member reported he/she exice licensed nurse F, and talked staff B and they told him/her exit was likely to have mily member reported there hat worked at night in the and he/she believed they reported they reported the existence. The resident had nily member he/she had asked existence into his/her room and had told the family member reported with the resident about it the resident 's story was regarding the incident reported mily member reported he/she are for the resident 's concerns of the story and people regardless.	F	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		175532	175532 B. WING		C 09/44/2044		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228		8/14/2014	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 223	description. The famnight he/she stayed, staff of the opposite direct care staff E. The resident had new up. The family member to cognition was very pand almost died, but last month or so. The resident had not had weeks. The family member the resident would a afraid if direct care so there and he/she ho not be working in the family member reposure the resident connight. Interview with the rerevealed the non-Castaff member that we him/her inappropriate was the same personight his/her family she/she was certain or reported he/she had different times when inappropriately. The a few nights during to (7/27/14-8/2/14) the night and he/she lay The A.P. grabbed the saw the A.P.'s long	ther staff member fitting that illy member confirmed the the non-Caucasian nursing gender that came in was he family member reported ter been one to make things per reported he/she visited twice a week every week. The reported the resident's oor when he/she was sick it had improved a lot in the refamily member reported the lany confusion in the last 3-4 tember reported he/she felt laways be uncomfortable or taff E continued working ped direct care staff E would refacility at night for sure. The red he/she just wanted to be all go to sleep peacefully at sident on 8/5/14 at 4:10 p.m. rucasian opposite gender orked at night that touched rely and made him/her scared in that came in the during the stayed. The resident reported of it. The resident had fought the staff member off 3 they tried to touch him/her resident reported there were he previous week A.P. came very quietly in the there awake and scared. The resident 's door and he/she fingers come around the the A.P. would just look in	F 2	23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMPLETED		
		175532	B. WING		C 08/14/2014	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	00/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 223	a.m. revealed when facility, the resident this time the resident ever had confusion. worked in the facilit the resident's house reported the resident confusion in the last the house. Staff Granoticed any concern Interview with on with 2:10 p.m. revealed confusion on that do Interview with direct p.m. revealed he/sh #3's house for the reported the resident first, went home, careally sick and was gone off of hospice	t care staff G on 8/5/14 at 9:59 If the resident readmitted to the had more confusion but at the was more with it and hardly. Staff G reported he/she had y since February and worked a about once a month. Staff G and thad not had any days of the 3 months he/she had worked reported he/she had not the with the resident's memory. It direct care staff E 8/5/14 at the resident had not had any	F 223	3		
	Interview with licens at 5:48 p.m. revealed nursing staff of the him/her. Interview with licens 2:08 p.m. revealed resident since he/sh reported the resider and then got really reported the resider	sed nursing staff J on 7/31/14 ed the resident did not like opposite gender to work with sed nursing staff J on 8/5/14 at he/she had worked with the ne was admitted. Staff J nt came in after a fall at home sick with a bad UTI. Staff J nt had occasional confusion, Staff J reported the resident's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
175532 B. WING			B. WING _				C 08/14/2014	
	ROVIDER OR SUPPLIER ALTH AND REHAB AT RI	EEDS COVE		STREET ADDRESS, 2114 N 127TH CT I WICHITA, KS 67		1 00/	14/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 223	confusion had gotten couple of weeks. Interview with social s 6:15 p.m. revealed he written statement from he/she did not questimany residents that copposite gender to pr B confirmed he/she did conversation with the the charge nurse. Interview on 7/31/14 with therapy staff D rep fearful to tell him/her reported he/she gave administrative staff A resident 's allegation gave administratives description of the occlater that day asked thad talked to the resident. Staff D reported he/she gave administrative staff A resident 's allegation gave administrative staff A resident 's allegation of the occlater that day asked thad talked to the resident. Staff D reported he/she 7/23/14 when staff D what the resident said nature of the allegatic allegation was reported the resident had reported the	services staff B on 7/31/14 at e/she confirmed his/her in 7/23/14. Staff B reported on it because there were did want nursing staff of the rovide personal cares. Staff did not document the resident anywhere, but told at 12:59 p.m. and 1:56 p.m. evealed the resident had his/her memory, but was not orted the resident was very about the abuse and his/her written statement to the day following the surrence for the resident, and he administrator if he/she dent. Staff D reported staff A he had talked to the orted he/she had not heard at time. If y staff C on 7/31/14 at 2:19 was with therapy staff D on told administrative staff A and included the sexual on. Staff D said since the end to administrative staff A, orted to him/her that the A.P. er by coming to the door and	F	223				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1 00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 223	Continued From pa	ge 15	F 22	3	
	7/31/14 at 12:20 p.r have any allegation	with administrative staff A on m. revealed the facility did not s of abuse that were not e/she always called them in.			
	1:27 p.m. revealed had a concern with member on 7/23/14 he/she went to inter the resident did not his/her problems. T things that made his reported he/she like gender and was not Staff A confirmed the/she had docume note. Staff A reported the staff of the opposite Staff A reported the staff of the opposite work in any house or reported if there we staff were moved at houses. Staff A repowerked primarily in	nistrative staff A on 7/31/14 at he/she thought the therapist the resident and a staff or 7/24/14. Staff A reported view the resident that evening identify who was causing he resident talked about m/her sound confused. Staff A at the staff of the same traffield to stay in the facility. The therapist's concern as ented in the OT daily progress at all of the night shift nursing a gender were non-Caucasian. The non-Caucasian direct care a gender had the possibility to depending on call-ins. Staff A are a call in, the direct care round to help cover all of the orted direct care staff E two of the four houses, but if staff E might work anywhere.			
	On 7/31/14 at 2:56 administrative staff staff told him/her at he/she talked to the members that work Staff A reported he/resident had comple specific staff membin general, or anyor going in his/her room				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 08/14/2014		
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2014	
A\//TA	ALTILAND DELIAD AT I	DEEDS 00VE		2	2114 N 127TH CT EAST			
AVIIA HE	ALTH AND REHAB AT I	REEDS COVE		٧	WICHITA, KS 67228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 223	Continued From pag	ge 16	F2	223				
		did not like opposite gender						
		e he/she had come back from						
		not mentioned anyone						
		orted he/she did not obtain						
		or document any of his/her						
	I .	ported the social services						
		l a written statement.						
		time, revealed an unsigned						
		aff A reported he/she did not						
		erapist about the concern, but						
		apist the next day that he/she						
		. Staff A reported the resident						
	had periods of confu	usion. Staff A reported the						
	resident had some t	imes where he/she was lucid						
	and times when the	resident had odd statements						
	mixed in with the luc	cid talk. Staff A reported						
	whenever he/she re	ceived an allegation of abuse,						
	neglect, or exploitati	ion (ANE), if there was a clear						
	A.P., he/she immed	iately suspended the A.P.						
	Staff A reported the	therapist told him/her the						
	resident would be ve	ery willing to tell him/her about						
	it. Staff A reported th	ne allegation would have been						
	considered ANE if the	ne resident were able to						
	corroborate the stor	y the therapist told. Staff A						
		not typically investigate an						
	allegation and then	report, but he/she did try to						
	gather as much info	rmation as possible before						
	calling something in	to report it and because the						
	resident would not o	or could not report anything to						
	him/her about the al	llegation, it was not reported.						
		rolling around in the grass						
		y, did not sound plausible						
	given some of the st	tatements the resident talked						
		ted if he/she truly thought						
		something to a resident,						
	he/she would have t	taken action and would have						
	done everything pos	ssible to protect the resident.						
	Staff A reported he/s	she did not interview residents						
		tion, but had interviewed						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	IPLE CONSTRUCTION NG		COMPLETED	
		175532	B. WING _			C
	ROVIDER OR SUPPLIER ALTH AND REHAB AT F	l		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	I	08/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	several related to ar of those interviewed reported during the he/she had not susphe/she did not have the resident could neeven race. Interview with admir 4:24 p.m. revealed twas a non-Caucasia the opposite gender resident could not pha.P., he/she decidenon-Caucasian nursus gender. Staff A reponon-Caucasian nursus opposite gender tha Staff A reponon-Caucasian staff touched them inapphate staff interviewed all opposite gender and evidence to keep the opposite gender sushe/she visited with the and reported he/she happened and reponed and reponed and reponed and reponed the gender were great president reported the in the grass happen was not feasible. Staft a bed sensor, and if the alarm would be whether staff disable whether staff disable whether staff disable whether staff disable staff.	nother investigation and none had concerns. Staff A time of the investigation, sended anyone because an A.P. to suspend because of pin it down to gender or histrative staff A on 8/5/14 at the therapist reported the A.P. an nursing staff member of a Staff A reported since the rovide a description of the dot o suspend all ling staff of the opposite red there were maybe 3 ing staff members of the tworked nights routinely. Staff completed resident allert and oriented resident in	F2	223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		175532	B. WING _			C 08/14/2014
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u>'</u>	00/14/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	Continued From pag	ge 18 gender were providing all the	F 2	23		
	personal cares to the the resident had not provided by a staff regender since 7/3/14 reported as an adde would be that there gender working in resident with consup.m. revealed the facuriveillance videos staff in the courtyard reported the facility bed alarm log, and of	e resident. Staff A reported had any personal cares nember of the opposite that staff knew of. Staff A endum to the correction plan would be no staff of certain				
	resident had a long Staff K reported all of expected to go in ar resident and take of the resident had a b was getting up on his resident lacked safe reported the resident more independent, I care during that time about 7/15/14. Staff	standing history of insomnia. direct care staff were ad provide fluids for the at the trash. Staff K reported ed alarm to alert staff he/she s/her own because the ty awareness. Staff K at was starting to become but had required incontinence e he/she was very sick until K reported the resident did at in place during the time				
	Neglect and Exploits employees were ed- suspected violations administrator IMME administrator or CE0 would ensure all alle involving mistreatme	ed facility policy for Abuse, ation, revealed all facility ucated that all alleged or should be reported to the DIATELY and the CI (Chief Executive Officer) aged or suspected violations ent, neglect or abuse were ported immediately to the				

PRINTED: 08/14/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175532	B. WING	B. WING			C 14/2014
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	14/2014
AVITA HEA	ALTH AND REHAB AT R	EEDS COVE			2114 N 127TH CT EAST VICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223 F 225 SS=L	hours of the incident. evidence to suspect to abused or neglected would not be allowed allowed access to the the investigation was. The facility failed to pabuse and mental an abuse on 7/23/14 was staff A. 483.13(c)(1)(ii)-(iii), (o	partment of Aging and complaint hotline within 24 If there was enough that an individual may have an elder, that individual to work in the facility or efacility until the outcome of known. Trotect resident #3 from guish after an allegation of s reported to administrative		223 225			
30-L							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 225	violations are thoroup revent further pote investigation is in proceed in the results of all investigation is in proceed to the administrator representative and with State law (includent, and if the administration agency incident, and if the administration in the state is a second or s	ve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 229	5	
	by: The facility census residents included i abuse. Based on of record review, the foreport an allegation sexual abuse and/o involving 1 sampled survey and certifica thoroughly investigated submit the results of survey and certificated days, and failed to potential abuse during the many submit the results of survey and certificated days, and failed to potential abuse during the many submit the facilitation of the facilitation of the facilitation was repointed in the facilitation of	totaled 66 residents with 3 in the sample reviewed for oservation, interview, and acility failed to immediately of employee to resident in inappropriate touching I resident #3 to the State tion agency, failed to ate the allegation, failed to f the investigation to the State tion agency within 5 working protect all residents from ing the investigation. Resident is of inappropriate touching by aff member of the opposite e potential to work in all four y. Resident #3 reported that to go to sleep at night. This red to Administrative staff failed to report, otect other residents after			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C 08/14/2014	
		175532	B. WING				
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CO 2114 N 127TH CT EAST WICHITA, KS 67228		0/14/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 225	Findings included: - Review of resident and physical dated of following diagnosis: to describe brain discovering a very broat range from mild, such personality changes dementia, seizures, Review of resident of dated 7/18/14 reveal (brief interview for mindicating moderate resident had inattent that was present and tired or had little enestaying asleep, or slithe previous 14. The severity score of 3, in the resident did not delusions, or any be required extensive as	t #3's signed physician history 1/17/14 revealed the encephalopathy (a term used ease, damage or malfunction d spectrum of symptoms that th as memory loss or subtle , to severe, such as	F 2:				
	and walking in the recontinent of bowel a bladder. Review of resident # initiated on 2/26/14,	aff for transfers, bed mobility, bom. The resident was always and occasionally incontinent of 43's comprehensive care plan revealed the resident was and bladder and requested					
	staff assistance with	toileting. On 7/18/14, staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING D. MUNC			(X3) DATE SURVEY COMPLETED	1` ′	
					С		
		175532	B. WING _		08/14/2014	1	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
۸\/ITA LIE	ALTH AND REHAB AT R	EEDS COVE		2114 N 127TH CT EAST			
AVIIA NE	ALIN AND REHAD AL P	EED3 COVE		WICHITA, KS 67228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE	ETION	
F 225	Continued From pag	e 22	F 2	25			
	requested not to hav gender for personal	e caregivers of the opposite cares. On 8/4/14, staff ion, but did not indicate what					
	Review of resident # therapy) daily progres revealed the resident of the opposite gend he/she was uncomform being in his/her room explained the staff magender would come he/she was in bed at touch his/her buttock resident he/she was incontinence pad was he/she did not think resident described of and the non-Caucas opposite gender (he alleged perpetrator, and said it was good	3's OT (occupational as note dated 7/23/14 at stated he/she had a nurse er that worked at night and ortable with that staff member in. The resident hesitated and number of the opposite in and touch him/her while in and touch him/her while in dacing the wall and would as. That nursing staff told the checking to see if his/her is dry, but the resident stated that was correct. The ther situations happening ian nursing staff of the inceforth referred to as the A.P.) would call it "therapy" for him/her. The resident					
	were gone, and the at the courtyard and was grass. The resident wanyone, he/she wou staff then reassured stated he/she was at The resident told sood did not want a nursir opposite gender with the social worker told requested nursing stated few nights, but he/sh by the nurses station	A.P. had him/her outside in as rough with him/her in the was afraid if he/she told ld be in trouble. The therapy the resident and the resident fraid to go to sleep at night. Sial services staff B he/she as staff member of the him/her in the shower and dd the head nurse the resident aff of the same gender only nothing happened the past he saw the A.P. working out the A.P. was gone. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 8/14/2014
	ROVIDER OR SUPPLIER	EEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	<u> </u>	0/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	resident believed the the resident's family r Sunday night and tha returned to his/her roo A.P. came into his/her family member stayed reported he/she feare against him/her if he/s Review of a notarized therapy staff D dated #3 reported to staff th nursing staff of the ophim/her uncomfortabl inappropriately on sevesident reported to sworker that he/she did the opposite gender in resident did not tell that time. The resident has since then and stated the couple of nights pexplained he/she was night in fear the A.P. Review of a notarized 7/31/14 revealed ther resident gave administreport of resident #3's touching and fear of the them went and discus co-worker therapy stawent to administrative reported the conversa resident explained to behavior. Staff D wroot against the sident conversa resident explained to behavior. Staff D wroot against the sident worker therapy stays and the sident explained to behavior. Staff D wroot against the sident worker therapy stays and the sident explained to behavior. Staff D wroot against the sident worker therapy stays and the sident explained to behavior. Staff D wroot against the sident worker therapy stays and the sident explained to behavior. Staff D wroot against the sident worker therapy stays and the sident explained to behavior. Staff D wroot against the sident explained to behavior.	A.P. was scared because nember stayed the past twas why the A.P. had not om. The resident stated the room on the night his/her did the night. The resident did the A.P. would retaliate she said anything. I witness statement by 7/24/14 revealed resident ere was a non-Caucasian posite gender that made er and touched him/her veral occasions. The taff D he/she told the social did not want nursing staff of this/her room and the er social worker why at that diseen the A.P. working that nothing had happened arior to 7/23/14. The resident erafraid of falling asleep at would be coming in. I witness statement dated apy staff D stated the strative staff A a verbal and allegations of inappropriate the A.P. on 7/23/14. Staff D sed the situation with ff C and then both of them er staff A and staff D verbally ation and concerns that the him/her about inappropriate the he/she gave a written statement the	F2	225		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175532	B. WING		C 08/14/2014	
	ROVIDER OR SUPPLIER	REEDS COVE	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1114 N 127TH CT EAST VICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 225	7/31/14 from therapy went with therapy s' A's office on 7/23/14 #3 reported as docunote on 7/23/14. The family member staynight (July 20th) and A.P., came into his/member there. The was not to be in his. resident said "I knowne, (gender) is after Review of the staff 6/29/14-8/2/14 reveropposite gender, woon night shift on 7/4 7/9/14, 7/10/14,	ed witness statement dated by staff C revealed he/she taff D to administrative staff 4 to talk about what resident amented in OT daily progress e resident told staff C his/her ed the night on a Sunday d that same staff member, the her room with his/her family resident told the A.P. he/she //her room and to get out. The wif (gender) is not bothering resone else here." assignment sheets from aled direct care staff E, of the orked in resident #3's house //14, 7/5/14, 7/6/14, 7/8/14, 1/14, 7/14/14, 7/15/14, 1/20/14, 7/22/14, 25/14, 7/28/14, and 7/29/14. The staff E worked a double - 10 p.m.) and 3rd (10 p.m. different house. Per facility d on yet another house for 3rd the week of 8/3/14-8/9/14, was scheduled to work in a president #3 lived in, on one shifts (2nd and 3rd) on set 2014 schedule, direct care the changed from resident #3's ate houses for 2nd shift and	F 225			
		ember revealed the resident oblem with nursing staff of the				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUC		' '	X3) DATE SURVEY COMPLETED			
			A. BOILD	_		، ا	
		175532	B. WING				14/2014
NAME OF P	ROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE	, 00,	
A)//TA !!E	41 TH 4ND DEHAD 4T D	NEEDO 001/E		2	114 N 127TH CT EAST		
AVIIA HE	ALTH AND REHAB AT R	REEDS COVE		v	VICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	reported direct care staff member of the oreferred to as the allowing and reset the resident #3 's family resident did have a lighad improved a lot reperson he/she knew member reported the a weekend direct care outside when there whim/her on the grounnight the he/she stay resident, staff E cam little shocked to see reported he/she knew as much confidence did before. At that time reported the facility habout the incident allowed reported he/she had and to social service allegations of inappromember of the opposition of the opposi	e resident 's family member staff E, the non-Caucasian opposite gender (now eged perpetrator/A.P.), came dent's fall alarm if it went off that bothered the resident. It went off that bothered the resident. It went off that bothered the resident was more around and rolled and. The resident reported the resident was no one around and rolled and. The resident reported the red the night with the re in and may have been a him/her. The family member we the family member and not talked to him/her. The family member talked with licensed nurse F, as staff B about the oppriate touching by a staff site gender and they told believe it was likely to have by member reported he/she resident about it several times story was always the same. With administrative staff A on a revealed the facility did not a for abuse that were not a complaint hotline because	F	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 08/14/2014
	ROVIDER OR SUPPLIER	REEDS COVE	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	<u>~</u>	F 2	25		
	D reported the residhim/her about the a gave his/her writter staff A the day follow the additional interview with admitical p.m. revealed had a concern with member on 7/23/14 he/she went to interview he/she like gender and was no Staff A reported the there was an opposed came and took the and rolled him/her asomething else the Staff A reported all of the opposite gender and house depending the opposite gender and house depending house depending house depending house depending work anywher the resident sexual nature of the allegation was reported the resident reporte	y, but was not confused. Staff dent was very fearful to tell abuse and reported he/she is statement to administrative wing the resident 's allegation. nistrative staff A on 7/31/14 at he/she thought the therapist the resident and a staff or 7/24/14. Staff A reported review the resident that e was very confused. Staff A ed the staff of the same the afraid to stay in the facility. Therapist's concern was that site gender staff member that resident out into the courtyard around in the grass and therapist was concerned with. For the night shift nursing staff der were non-Caucasian. Staff der were non-Caucasian. Staff der were non-Caucasian. Staff der were non-Caucasian direct care staff of rhad the possibility to work in an on call-ins and staff A estaff E worked primarily in here was a call-in, staff E re. The staff C on 7/31/14 at 2:19 are was with therapy staff D on D told administrative staff A aid and it did include the estaff between the door, looking by coming to the door, looking				
	around and then lea On 7/31/14 at 2:56	eving. p.m., interview with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 501251			Ι,	С	
		175532	B. WING			1	/14/2014	
NAME OF P	ROVIDER OR SUPPLIER	111111		9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	14/2014	
					114 N 127TH CT EAST			
AVITA HE	ALTH AND REHAB AT	REEDS COVE			VICHITA, KS 67228			
				•			I	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE	
F 225	Continued From pa	age 27	F	225				
	-	A revealed he/she did not						
		ments or document any of						
		n, but reported social services						
		d a written statement.						
	•	time, revealed an unsigned						
		taff A reported he/she did not						
	follow up with the the	herapist about the concern.						
	Staff A reported the	e next day after the therapist						
		the allegation, the therapist						
	came in and asked	him/her what staff A had done						
		rovided a written statement.						
		e resident had periods of						
		eported whenever he/she						
		ion of abuse, neglect, or						
	'	if there was a clear A.P.,						
		suspended the A.P. Staff A vist told him/her the resident						
		ng to tell him/her about it. Staff						
		gation would have been						
		the resident were able to						
		ry the therapist told. Staff A						
		I not typically investigate an						
	·	report it to the State agency,						
		o gather as much information						
		calling something in to report it						
	and because the re	esident would not or could not						
	report anything to h	nim/her about the allegation, so						
	it was not reported.	Staff A reported that rolling						
		s and calling it therapy, did not						
		en some of the statements the						
		out. Staff A reported if he/she						
		one had done something to a						
	'	ould take action and would do						
		e to protect the resident. Staff A						
		d not interview residents						
		ation, but had interviewed						
		nother investigation and none						
		d had concerns. Staff A						
	i reported during the	time of the investigation,					1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		175532	B. WING _			C 8/14/2014	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228		00.1.0001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 225	Continued From pag	ge 28	F 2	25			
	he/she did not have the resident could no even race.	ended anyone because an A.P. to suspend because ot pin it down to gender or					
	4:24 p.m. revealed t was a non-Caucasia the opposite gender he/she could not pro	nistrative staff A on 8/5/14 at he therapist reported the A.P. an nursing staff member of . Staff A reported since ovide a description of the A.P.,					
	nursing staff of the c days after therapy s him/her. Staff A repo non-Caucasian nurs	uspend all non-Caucasian opposite gender on 7/31/14, 8 taff reported the allegation to orted there were maybe 3 taff members of the					
	Staff A reported the interviews of every a the building and spe	t worked nights routinely. staff completed resident alert and oriented resident in cifically asked if any to the opposite gender had					
	staff interviewed all opposite gender and evidence to keep the	ropriately. Staff A reported the non-Caucasian staff of the d were unable to identify any e non-Caucasian staff of the					
	resident reported the in the grass happen was not feasible. St	spended. Staff A reported the e incident about rolling around ed during the day, which just aff A reported the facility had					
	the opposite gender notified him/her of the	If the 4 non-Caucasian staff of at the time the surveyor are immediate jeopardy on er questioning, he/she					
	the night shift for 7/3 of the facility's plan	the 4 non-Caucasian staff for 81/14. Staff A reported as part of correction for the , every single employee					
	participated in the in neglect, and exploita	-services about abuse, ation. Staff A reported he/she					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		175532	B. WING			C
	ROVIDER OR SUPPLIER		B. Wille _	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	1 (08/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	them had very consi- resident preferred no gender and had not caregivers since 7/3 resident had not had by a staff member of 7/3/14 that staff knew addendum to the conthere would be no stain the Saghbene hou Interview with consu- p.m. revealed the fareaurveillance videos of notified of an immedid did not see staff in the Staff K reported the resident's bed alarm pattern of the reside night and the reside night and the reside night and take out the resident had a b was getting up on hi resident lacked safe reported the residen more independent, the care during the time about 7/15/14. Staff have the bed sensor he/she required incor reported when the far investigation regardi could not substantia reported the facility the assignments so ther	pposite gender and each of stent stories and knew the ursing staff of the same wanted opposite gender /14. Staff A reported the any personal cares provided the opposite gender since of of. Staff A reported as an errection plan would be that aff of certain gender working use. Itant staff K on 8/5/14 at 4:48 cility had reviewed the of July 4th after they were iate jeopardy situation and the courtyard with the resident. If acility reviewed the log, and could not find a not being more restless at the had a long standing history reported all direct care staff in and provide fluids for the the trash. Staff K reported the sherown because the synameness. Staff K twas starting to become but had required incontinence he/she was very sick until K reported the resident did in place during the time intinence care. Staff K	F 2	25		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		175532	B. WING			08/	14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT RI	EEDS COVE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 114 N 127TH CT EAST VICHITA, KS 67228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Interview with adminis 8/6/14 at 8:27 a.m. re report any allegations investigate them. Sta staff interviewed the rable to talk, interview directly with the resid of the injury or ANE a reported staff assess the physician. Staff A interview at least 3 al about a situation clos Staff A reported if the individual was susper reported the residents on admission they co concerns during the areminded during resid Ombudsman (resider number and complair the residents were alsoncerns without fear staff A reported the fa allegations of ANE to 24 hours at the latest was made and if there of a crime, the facility	e 30 strative nursing staff A on evealed the facility would for a ANE to the State and ff A reported to investigate, resident if the resident was red the staff that worked ent close to the time frame ellegedly occurred. Staff A reported he/she tried to retrain and oriented residents re to what the allegation was re was an identified A.P., the red immediately. Staff A reported immediately. Staff A reported immediately. Staff A reported in and families were informed and feel free to voice their redmission process and dent council of the red advocate program) and hotline. Staff A reported reported in any the complaint hotline within or as soon as the allegation re was reasonable suspicion	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
	actions, it depended allegation. Staff A repimmediate corrective issue to the Quality A reported they looked education, in-services need was identified.	on the nature of the orted the facility conducted actions, then brought the ssurance committee. Staff A at the need for staff s, and trained all the staff if a Observation during the aff A read from the facility					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		175532	B. WING _			C 08/14/2014	
	ROVIDER OR SUPPLIER	REEDS COVE		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 225	administrative staff explain why he/she abuse against resic hotline. Staff A repor in the facility that we felt like the allegation then he/she would be reported when he/s preliminary investig and he/she did not suspend. Review of the unda Neglect and Exploit employees were edu suspected violation administrator IMME administrator or CE would ensure all all involving mistreatm investigated and re KDADS (Kansas De Disability Services) hours of the incider to suspect that an in neglected an elder, allowed to work in the facility until the was known. The facility failed to investigation of abu allegation of employ and/or inappropriate #3 to the State surv failed to thoroughly	at 8:33 a.m. revealed A reported he/she could not did not call in the allegation of lent #3 to the complaint orted there was a lot going on eek. Staff A reported if he/she on would be substantiated, have called it in. Staff A he completed his/her ation, it did not come together have a definite A.P. to ted facility policy for Abuse, ation, revealed all facility fucated that all alleged or s should be reported to the	F 2	25			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175532	B. WING				C
	ROVIDER OR SUPPLIER ALTH AND REHAB AT RI		D. Wille	ST 21	TREET ADDRESS, CITY, STATE, ZIP CODE 14 N 127TH CT EAST ICHITA, KS 67228	08/	14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	8/5/14 at 5:00 p.m. w their investigation, proto all employees on resuspended all non-Coopposite gender that the immediate jeopar non-Caucasian staff of the facility 's investig	e immediate jeopardy on when the facility completed ovided re-education on ANE eporting allegations, aucasian staff of the were in the building the time rdy was identified, then all of the opposite gender until gation was complete. The was also removed from the expected to return.	F	2225			
F 242 SS=D	thoroughly investigate abuse, exploitation, at the investigation, rer severity of an F. 483.15(b) SELF-DET MAKE CHOICES The resident has the schedules, and health her interests, assessinteract with member inside and outside the	e and report an allegation of and protect residents during mained at a scope and TERMINATION - RIGHT TO right to choose activities, h care consistent with his or ments, and plans of care; so of the community both e facility; and make choices or her life in the facility that	F	242			
	by: The facility had a cer residents selected for observation, interview facility failed to honor	r is not met as evidenced nsus of 66 residents, with 3 r sample. Based on w and record review, the r resident #3's preference to of the opposite gender.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175532	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 242	Continued From pag	ge 33	F 242		
	Findings included:				
	and physical dated a following diagnoses used to describe bra malfunction covering symptoms that rang loss or subtle person such as dementia, such as demential demential demands of the such as deman	encephalopathy (a termal disease, damage or g a very broad spectrum of e from mild, such as memory nality changes, to severe, seizures, coma, or death).			
	CAA (care area assorted the resider dementia and was a of confusion. The reneeds known. The rassistance in decision of the resident of the res	#3's Cognitive Loss/Dementia essment) dated 8/1/14 int had a diagnosis of alert and oriented with periods esident could make his/her resident required staff on making due to impaired ent usually understood others derstood by others.			
	dated 4/18/14 revea	#3's temporary care plan aled staff developed a n for resident #3 upon his/her			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175532	B. WING		C 08/14/2014
	ME OF PROVIDER OR SUPPLIER TITA HEALTH AND REHAB AT REEDS COVE X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	2	TREET ADDRESS, CITY, STATE, ZIP CODE 114 N 127TH CT EAST VICHITA, KS 67228	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 242	readmission to the plan, resident #3 pr same gender. On intervention to the r plan alerting staff the bladder and contines staff assistance for directed staff to mo assistance when no resident requested opposite gender for Review of resident revealed the reside confusion and able Review of resident revealed the reside confusion and able Review of a nurses 7/16/14 at 2:24 a.m. alert and oriented to could voice his/her bed alarm (device to attempted to get up every 2 hour check his/her room. The massistance of one p front wheeled walked (activities of daily like the social services staff several weeks prior that he/she would pursing staff of his/his/his/his/his/his/his/his/his/his/	facility. According to that care eferred only care givers of the 7/18/14, staff added an esident's comprehensive care he resident was incontinent of ent of bowel and requested toileting for safety. It also mitor pericare and provide edded and alerted staff the not to have caregivers of the repersonal cares. #3's nurses note dated 5/8/14 and was alert with some to make his/her needs known. #3's progress notes from alled no mention of the grounding staff of the opposite of him/her. note for resident #3 dated and revealed the resident was operson, place, and time and needs. The resident had a used to alert staff the resident was in esident required extensive erson with ambulation with a er, toileting, and ADLs	F 242		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	` ′	ATE SURVEY DMPLETED
		175532	B. WING_			C 08/14/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 242	of the conversation. charge nurse and ad resident's request to his/her same gender. Review of an OT (or progress note dated resident stated he/sh the opposite gender uncomfortable and din his/her room. The services staff B he/sh staff member of the din the shower and the nurse the resident has the same gender onl. Review of the 24 hou July 2014 revealed for 7/3/14 day shift. The aides of the opposite Review of the staff a 6/29/14-8/2/14 reveal care staff of the opposite gender nurs resident #3's house. Opposite gender nurs resident #3's house. Review of a notarize therapy staff D dated #3 had reported to sinursing staff of the oroom. The resident ruthe social worker that staff of the opposite gender nurs resident ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruthe social worker that staff of the opposite gender ruther st	The social worker let the ministrator know of the have a staff member of give him/her a shower. cupational therapy) daily 7/23/14 revealed the lee had a night shift nurse of which made him/her id not want that staff member resident told the social he did not want a nursing apposite gender with him/her lee social worker told the head and requested nursing staff of y. It nurse report sheets for or resident #3: resident did not want any	F 2	42		

1, 7		IDENTIFICATION NI IMPED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175532	B. WING		C 08/14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT I	REEDS COVE	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	, 30/1 1/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 242	Continued From pa	ge 36	F 242		
	7/28/14 revealed re	ily treatment note dated sident #3 stated the direct osite gender had been in to			
	#3's family member especially had a pro opposite gender. Th family member he/s	at 12:00 p.m. with resident revealed the resident oblem with nursing staff of the resident had reported to the he had asked staff E not to om and had told other staff			
	family member reve	at 3:47 p.m. with resident #3's aled the night he/she stayed e staff E came in during the			
	gender) on 7/31/14 had only helped res M reported the resid	care staff M (of the opposite at 9:03 a.m. revealed he/she ident #3 once or twice. Staff dent required to have his/her ct changed in the morning.			
	at 5:48 p.m. reveale	sed nursing staff J on 7/31/14 and resident #3 did not like apposite gender to work with			
	6:15 p.m. revealed the/she did not want gender for showers	I services staff B on 7/31/14 at the resident told him/her that nursing staff of the opposite and the resident did not say led he/she told the charge			
		y policy, dated 2/11/14, for evealed residents were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175532	B. WING				C 14/2014
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE				21	TREET ADDRESS, CITY, STATE, ZIP CODE 14 N 127TH CT EAST ICHITA, KS 67228	1 00/	14/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	to his/her service pro The facility failed to h not to have caregiver	ved to make choices related viders. onor resident #3's choice s of the opposite gender.		242			
F 280 SS=D	The resident has the incompetent or other incapacitated under t	right, unless adjudged wise found to be the laws of the State, to g care and treatment or	F:	280			
	within 7 days after the comprehensive assessinterdisciplinary team physician, a registere for the resident, and disciplines as determined, to the extent prathe resident, the resident legal representative;	e plan must be developed e completion of the ssment; prepared by an , that includes the attending of nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed in of qualified persons after					
	by: The facility census to residents included in observation, interview facility failed to review	is not met as evidenced otaled 66 residents with 3 the sample. Based on v and record review, the v/revise resident #3's care sident's preference to have vers. (#3)					

NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	, ,		IDENTIFICATION NUMBER		PLE CONSTRUCTION IG	(X	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE (A4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG OF THE PRECED			175532	B. WING			C 08/14/2014	
FREEIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 38 Findings included: - Review of resident #3's signed physician history and physical dated 4/17/14 revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14. Review of resident #3's profile page revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14. Review of resident #3's significant change MDS (minimum data set) dated 7/18/14 revealed the resident has a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for tolleting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bladder. Review of resident #3's Cognitive Loss/Dementia CAA (care area assessment) dated 8/1/14 revealed the resident was always and and a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance to decision making due to impaired			I		2114 N 127TH CT EAST	I	00/14/2014	
Findings included: - Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnoses: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death). Review of resident #3's profile page revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14. Review of resident #3's significant change MDS (minimum data set) dated 7/18/14 revealed the resident had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder. Review of resident #3's Cognitive Loss/Dementia CAA (care area assessment) dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
- Review of resident #3's signed physician history and physical dated 4/17/14 revealed the following diagnoses: encephalopathy (a term used to describe brain disease, damage or malfunction covering a very broad spectrum of symptoms that range from mild, such as memory loss or subtle personality changes, to severe, such as dementia, seizures, coma, or death). Review of resident #3's profile page revealed the resident was originally admitted 11/1/13, and readmitted on 4/17/14 and 5/30/14. Review of resident #3's significant change MDS (minimum data set) dated 7/18/14 revealed the resident had a BIMS score of 11, indicating moderate cognitive impairment. The resident required extensive assistance of one staff for toileting and personal hygiene and limited assistance of one staff for transfers, bed mobility, and walking in the room. The resident was always continent of bowel and occasionally incontinent of bladder. Review of resident #3's Cognitive Loss/Dementia CAA (care area assessment) dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired	F 280	Continued From page	e 38	F 2	80			
CAA (care area assessment) dated 8/1/14 revealed the resident had a diagnosis of dementia and was alert and oriented with periods of confusion. The resident could make his/her needs known. The resident required staff assistance in decision making due to impaired		- Review of resident and physical dated 4, following diagnoses: used to describe brai malfunction covering symptoms that range loss or subtle person such as dementia, see Review of resident #3 resident was originall readmitted on 4/17/14 Review of resident #4 (minimum data set) of resident had a BIMS moderate cognitive in required extensive as toileting and personal assistance of one stall and walking in the rocontinent of bowel are	revealed the encephalopathy (a term of disease, damage or a very broad spectrum of from mild, such as memory ality changes, to severe, eizures, coma, or death). B's profile page revealed the y admitted 11/1/13, and 4 and 5/30/14. B's significant change MDS ated 7/18/14 revealed the score of 11, indicating inpairment. The resident esistance of one staff for I hygiene and limited iff for transfers, bed mobility, om. The resident was always					
and was usually understood by others. Review of resident #3's Urinary		CAA (care area asse revealed the resident dementia and was all of confusion. The res needs known. The re assistance in decision cognition. The reside and was usually under	ssment) dated 8/1/14 had a diagnosis of ert and oriented with periods ident could make his/her sident required staff n making due to impaired nt usually understood others erstood by others.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175532	B. WING		C 08/14/2014
	NAME OF PROVIDER OR SUPPLIER AVITA HEALTH AND REHAB AT REEDS COVE			STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	00/14/2014
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 280	dated 8/1/14 reveal occasional urinary in urinary frequency a with a recent UTI (uthe resident receive required extensive personal hygiene adignity. Review of resident dated 4/18/14 reveal only caregivers of the but when the resided 5/30/14, that inform his/her comprehensions. Review of resident initiated on 2/26/14 schedule portion of resident was continued to a side of the intervers of the interversident requested opposite gender for staff revised the care	elling Foley Catheter CAA led the resident had incontinence and his/her and incontinence had increased urinary tract infection) which ed antibiotics for. The resident assistance with toileting and and wore incontinent briefs for #3's temporary care plan aled the resident preferred the same gender as him/her, ent readmitted to the facility on nation was not included in	F 28	0	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		175532	B. WING		08/14/2014
	ROVIDER OR SUPPLIER ALTH AND REHAB AT	REEDS COVE	2-	TREET ADDRESS, CITY, STATE, ZIP CODE 114 N 127TH CT EAST VICHITA, KS 67228	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 280	social services staff several weeks prior that he/she would provide that he/she would provide the his/resident did not list complain about a segender. The resided during the course of worker let the charge know of the resider member of his/her sender. Interview on 7/31/1 #3's family member especially had a propoposite gender. The family member he/secome into his/her recome into his/	statement from the former f B dated 7/23/14 revealed r, resident #3 had told him/her prefer to receive showers from the same gender. The anyone specific and did not taff member of the opposite int was confused at times of the conversation. The social genurse and administrator the revealed the resident gender give him/her a same gender give him/her a same gender give him/her a she had asked staff E not to boom and had told other staff the taff E in his/her room. Seed nursing staff J on 7/31/14 at resident #3 did not like opposite gender to work with the same staff of the opposite gender to gender that the training staff of the opposite gender to provide and the residents that did want opposite gender to provide off B confirmed he/she did not	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		175532	B. WING		C	044
	ROVIDER OR SUPPLIER ALTH AND REHAB AT RI	111		STREET ADDRESS, CITY, STATE, ZIP CODE 2114 N 127TH CT EAST WICHITA, KS 67228	08/14/2	014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
F 280	1:27 p.m. revealed reliked the staff of the sinterviewed. Staff A renursing staff of the opnon-Caucasian. Interview with adminida:24 p.m. revealed stauspended non-Caucawere very consistent not want staff of the chim/her and had not varegivers since 7/3/resident had not had by a staff member of 7/3/14 that he/she kn. Review of the facility Care Plan Revisions update the resident's in care or treatment at the facility failed to use the comprehensive care did not want caregivers.	estrative staff A on 7/31/14 at esident #3 stated he/she ame gender when eported all of the night shift eposite gender were estrative staff A on 8/5/14 at aff A reported all of the easian opposite gender staff and knew resident #3 did epposite gender to care for wanted opposite gender 14. Staff A reported the any personal cares provided the opposite gender since ew of. policy, dated 12/27/13, for revealed staff were to care plan with any changes approaches.	F 2	80		